

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01631

1667

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for us as a burial transit permit.

VS A15C 1-5 I.D.M.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural— Bel Air		MARYLAND STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Maulsby St., Bel Air, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Harford Convalescent Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Joseph Henry Ayres		February 24, 1955	
5. SEX Male	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH Feb. 26, 1880
9. AGE last birthday 74 yrs.	10. KIND OF BUSINESS OR INDUSTRY U.S. mail delivery	11. BIRTHPLACE (State or foreign country) Harford County, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Ayres	14. MOTHER'S MAIDEN NAME ANN R. ROBINSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No	16. SOCIAL SECURITY NO. 218-18-7926		
17. INFORMANT & ADDRESS Mrs. Elizabeth A. Caplan Elton, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4221 IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS, terminating		INTERVAL BETWEEN ONSET AND DEATH 3 da	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Ch. Cardio-vascular disease GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Forest Hill	(County) Md. (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell	
22. I hereby certify that I attended the deceased from Sept. 1953, to Feb. 24, 1955, that I last saw the deceased alive on Feb. 23, 1955, and that death occurred at 6:30 AM from the causes and on the date stated above. SIGNATURE Willard P. Hudson M.D. Forest Hill Md. DATE SIGNED 2-24-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 26, 1955	NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens	LOCATION (City, town, or county) Bel Air, Harford County, Md. (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Priscilla Lowood		
DATE 2-25-55	25. FUNERAL DIRECTOR'S SIGNATURE Foster Funeral Home Bel Air, Md.		

STATE OF CALIFORNIA

CERTIFICATE OF DEATH

Feb 25, 1980 JF

2.2.1 Burial or Cremation Certificate  
MURKIN, GENEVIEVE MARY

Feb 25, 1980

MURKIN, GENEVIEVE MARY

FEBRUARY 25, 1980

1980

DECEASED

1. Name of deceased: MURKIN, GENEVIEVE MARY

2. Name of deceased: MURKIN, GENEVIEVE MARY

3. Name of

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1668 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01632

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Edgewood		LENGTH OF STAY (In this place) 55 yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewood	
3. NAME OF DECEASED (Type or Print) BLANCHE ELIZABETH BAIR		4. DATE OF DEATH Feb. 6 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 24, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Cecil Co., Maryland
13. FATHER'S NAME John Harris		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Aldie L. Bair, Edgewood, Maryland.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  356.1 Immediate cause (a) HYPOSTATIC PNEUMONIA  Antecedent cause(s) (b) AMYOTROPHIC LATERAL SCLEROSIS Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
INTERVAL BETWEEN ONSET AND DEATH 14 MONTHS			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE			
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
ADDRESS			
22. I hereby certify that I attended the deceased from 1 NOV., 1953., to 6 FEB., 1955., that I last saw the deceased alive on 4 FEB., 1955., and that death occurred at 2:45 A.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED B. DeWitt Jr. M.D. BOX 95, EDGEWOOD, MD. 6 FEB 55			
23. BURIAL, CREMATION REMOVAL (Specify) Bel Air		DATE THEREOF Feb. 8, 1955	
NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		LOCATION (City, town, or county) Bel Air, Harford, Md.	
VS. A15 DATE REC'D BY LOCAL REG. Feb. 7, 1955		REGISTRAR'S SIGNATURE Norma G. Moore	
24. FUNERAL DIRECTOR Howard A. McComas & Son, Abingdon, Md.		ADDRESS	

RECEIVED

FEB 9 1955

BUREAU V. S.

1669

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

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**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 181

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Aberdeen</b>		MARYLAND LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rural #2 - Kalubacher's Store</b>		STATE <b>MD</b> COUNTY <b>Harford</b> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Aberdeen Rural #2</b>	
3. NAME OF DECEASED: (Type or Print) <b>Ronald Edward Barton</b>		(First) <b>Ronald</b> (Middle) <b>Edward</b> (Last) <b>Barton</b>	4. DATE OF DEATH <b>February 10</b> 1955
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>7-21-1954</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Refugee</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Refugee</b>	9. AGE last birthday: IF UNDER 1 YEAR yrs. <b>7</b> Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.
13. FATHER'S NAME: <b>Clarence Barton</b>		14. MOTHER'S MAIDEN NAME: <b>Norma Lee Hughes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <b>—</b>	17. INFORMANT & ADDRESS: <b>Aberdeen Police Dept Aberdeen MD</b>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <b>490X</b> Immediate cause (a) <b>Lobar pneumonia</b> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) _____ giving rise to the above cause DUE TO stating underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.. INJURY	21c. (City or town) _____ (County) _____ (State) _____
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <b>Sherald C Palmer</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Removal</b>		DATE THEREOF <b>2/11/55</b>	NAME OF CEMETERY OR CREMATORIAL <b>Seltzer family cemetery near Seltzer West Virginia</b>
DATE REC'D BY LOCAL REG. <b>Feb 11-1955</b>		REGISTRAR'S SIGNATURE <b>Mellie G. Terry</b>	LOCATION City, town, or county <b>near Seltzer West Virginia</b> (State) <b>ADDRESS</b> <b>John G. Tanning Aberdeen MD</b>
24. FUNERAL DIRECTOR ADDRESS <b>10V4172404</b>			

BUREAU Y. S

FEB 14 1995

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BUREAU Y. S.

## 1670 CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Aberdeen

Three hours

HOSPITAL OR  
INSTITUTION OR U. S. Army Hospital

STREET ADDRESS Aberdeen Proving Ground

3. NAME OF  
DECEASED:  
(Type or Print)

Robert

Lee

## (First) (Middle)

(Last)

4. DATE (Month)  
OF  
DEATH: Feb

6

1955

## 5. SEX:

Male

Female

Male&lt;/

RECEIVED  
FEB 9 1968

BUREAU V. S.

RECEIVED  
FEB 9 1968

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01635

1650

**CERTIFICATE OF DEATH**

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Maryland TOWNS Havre de Grace 24	
24 Havre de Grace		20 years		STREET ADDRESS		(If rural give location) 622 N. States Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Harford Memorial							
<b>3. NAME OF DECEASED</b> (First) Minnie Bell (Middle) Braswell (Last)				<b>4. DATE (Month) OF DEATH</b> Feb 21 1955			
5. SEX <input checked="" type="checkbox"/> F	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Widowed Apr. 18 1886	9. AGE last birthday 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John		14. MOTHER'S MASTEN NAME Edwards					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. FLORENCE B. FREEMAN ABERDEEN, MD.			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.0 IMMEDIATE CAUSE (A) PNEUMONIA ANTECEDENT CAUSE(S) DUE TO CARDIAC DECOMPRESSION 2 weeks DISEASES OR CONDITIONS, IF ANY, (B) ARTERIOSCLEROTIC HEART DISEASE 1 year GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 day			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, leinery, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) 19.55		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from 2/3 19.55, to 2/21 19.55, that I last saw the deceased alive on 2/21 19.55, and that death occurred at 9:55 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> Havre de Grace, Md. M.D. <b>DATE SIGNED</b> 2/21 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF Feb. 24, 1955		NAME OF CEMETERY OR CREMATORIUM ANGEL HILL Cem.		LOCATION (City, town, or county) HAVRE DE GRACE, MD	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE DATE Feb. 24, 1955		P. L. Lewis, M.D.		FUNERAL DIRECTOR'S SIGNATURE P. Madison Mitchell		ADDRESS HAVRE DE GRACE, MD	

DEATH CERTIFICATE

1954-1955

DEATHS OCCURRED DURING THE PERIOD FROM JANUARY 1, 1954, TO DECEMBER 31, 1955.

BUREAU V. S.  
RECEIVED  
FEB 25 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# 1651 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01636

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: <b>Harford</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN</b> <b>Havre-de-Grace</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Perryville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Harford General Hospital</b>		STREET ADDRESS <b>(If rural, give location)</b>	
3. NAME OF DECEASED (Type or Print) <b>George W. Brown</b>		4. DATE OF DEATH <b>February 6 1953</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>12-28-1884</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Penn Rail Road Track Supervisor</b>		9. AGE last birthday If under 1 year Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> Yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Brown</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <b>Rose Brown, Perryville, Md</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <b>Cerebral Thrombosis</b>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Generalized arteriosclerosis</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetic mellitus</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> m.	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/2</b> , 19 <b>55</b> , to <b>2/6</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>2/6</b> , 19 <b>55</b> , and that death occurred at <b>3:40 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>Frederick J. Hallinan M.D.</b> ADDRESS <b>721 Charles St., Baltimore, Md.</b> DATE SIGNED <b>2/6/55</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOFT <b>Feb. 9 1955</b> NAME OF CEMETERY OR CREMATORIAL <b>Angel Hill</b> LOCATION (City, town, or county) <b>Havre-de-Grace, Md.</b> (State) <b>Md.</b>	
DATE REC'D BY LOCAL REG. <b>Feb. 9 1955</b> Li. T. Lewis M.D.		REG. DATE REC'D BY LOCAL REG. <b>Feb. 9 1955</b> Li. T. Lewis M.D. 24. FUNERAL DIRECTOR <b>Frederick Patterson &amp; Son</b> ADDRESS <b>Perryville, Md.</b>	

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1995



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1652

01637

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND		STATE CITY (If outside corporate limits, write RURAL and give nearest town)	MARYLAND COUNTY			
24 HAVRE DE GRACE	LENGTH OF STAY (in this place)		24 HAVRE DE GRACE	STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71 HARFORD 115 Market St.	1 mo		115 Market St.				
<b>3. NAME OF DECEASED (Type or Print)</b>				<b>4. DATE OF DEATH</b>			
DAVID ALLEN Bucci				Feb. 20 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 8/2/1953	9. AGE last birthday 1 yr.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 18	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Hardeyland, MI		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Alfred Bucci				14. MOTHER'S MAIDEN NAME Edna E. Bernard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Alfred Bucci, Havre de Grace				18. MEDICAL CERTIFICATION Influenza - Pneumonia Dehydration - Accliosis			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 492X IMMEDIATE CAUSE (A) Influenza - Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Dehydration - Accliosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Havre de Grace		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 20, 1955, to Feb. 20, 1955, that I last saw the deceased alive on Feb. 20, 1955, and that death occurred at 9:30 A.M. from the causes and on the date stated above. SIGNATURE E. L. Lewis MD M.D. Hare de Grace							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/25/55	NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		ADDRESS (Street, city, town, state) Havre de Grace, Md.		
24. REC'D BY REGISTRAR DATE Feb. 22-55		REGISTRAR'S SIGNATURE E. L. Lewis, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE E. L. Lewis, M.D.		ADDRESS Havre de Grace, Md.		

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01638

1653

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

**INSTRUCTIONS**  
**WARNING TO PHYSICIAN OR HOSPITAL:** The death certificate must be retained by the physician or hospital until the deceased has been buried or cremated. The bottom copy may be retained by the physician or hospital.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for mailing as a burial transit permit.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Bel Air</b>		STATE <b>Md.</b> COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Bel Air</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (In this place) <b>6 yrs.</b>	
STREET ADDRESS		ADDRESS <b>Mausby STREET</b> (If rural give location)	
<b>3. NAME OF DECEASED</b> (First) <b>MILTON</b> (Middle) <b>J.</b> (Last) <b>BULL, Sr.</b>		<b>4. DATE OF DEATH</b> <b>February 20, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 14, 1885</b>
9. AGE last birthday <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK Bull</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Elliott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>UNK</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-16-0549</b>	
17. INFORMANT & ADDRESS <b>SEWELL Bull, Bel Air, Md.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>44 - Uremia, terminating</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 da.</b>	
IMMEDIATE CAUSE <b>(A) Uremia, terminating</b>		ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>(B) Hypertensive Cardio-renal disease, chronic</b>	
		DUE TO <b>(C)</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) <b>Forest Hill, Md.</b> (County) <b>M.D.</b> (State)			
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Feb. 22, 1955</b> M.		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 19, 1930</b> , to <b>Feb. 20, 1955</b> , that I last saw the deceased alive on <b>Feb. 19, 1955</b> , and that death occurred at <b>... M.</b> from the causes and on the date stated above. SIGNATURE <b>Willard P. Hudson, M.D.</b> ADDRESS <b>Forest Hill, Md.</b> DATE SIGNED <b>2-20-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb 22, 55</b> NAME OF CEMETERY OR CREMATORIAL <b>BEL AIR MEMORIAL GARDENS</b> LOCATION (City, town, or county) <b>BEL AIR HARFORD CO., BEL AIR</b> M.D. (State)	
24. REC'D BY REGISTRAR <b>Brucille Louwerd</b>		REGISTRAR'S SIGNATURE <b>Foster Funeral Home</b> ADDRESS <b>Joseph W. Foster</b>	
DATE <b>2-21-55</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>	

407

FEB 24 1968

2411 N. Charles Street, Baltimore

01639

## CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH COUNTY HARFORD		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAURE de GRACE		LENGTH OF STAY (in this place) 3 1/2 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 HARFORD Memorial Hosp.		STREET ADDRESS 312 LAFAYEHE	
3. NAME OF DECEASED (Type or Print)	(First) BEWIAH	(Middle)	(Last) COULTER
4. SEX FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	4. DATE OF DEATH FEBRUARY 10, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	5. DATE OF BIRTH 3-26-1899	9. AGE last birthday 55 yrs.
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY WATERS	14. MOTHER'S MAIDEN NAME SARA FLETCHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Howard L. Coulter, 312 Lafayette St., Baltimore	
18. MEDICAL CERTIFICATION  I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) Carcinoma & others Antecedent cause(s) (b) General carcinomatous Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) adnexa  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION Jan 1955	19b. MAJOR FINDINGS OF OPERATION carcinoma & others	20. AUTOPSY! Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 1, 1955, to Feb 10, 1955, that I last saw the deceased alive on Feb 10, 1955, and that death occurred at 1 A.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Charles J. Kelly, Jr. 100-1200 Jan 21, 1955			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 2/12/55	NAME OF CEMETERY OR CREMATORIAL Angel Hill	LOCATION (City, town, or county) Baltimore, Md. (State)
DATE REC'D BY LOCAL REG. 2/12/55	REG. S. Lewis	24. FUNERAL DIRECTOR S. Lewis	ADDRESS Baltimore, Md.
REG. S. Lewis			

BUREAU V. S.

17B 43-70

LEADER

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Dr. Palmer, D.C., stated that I fill in this certificate. Robert Barthel, M.D.

1671

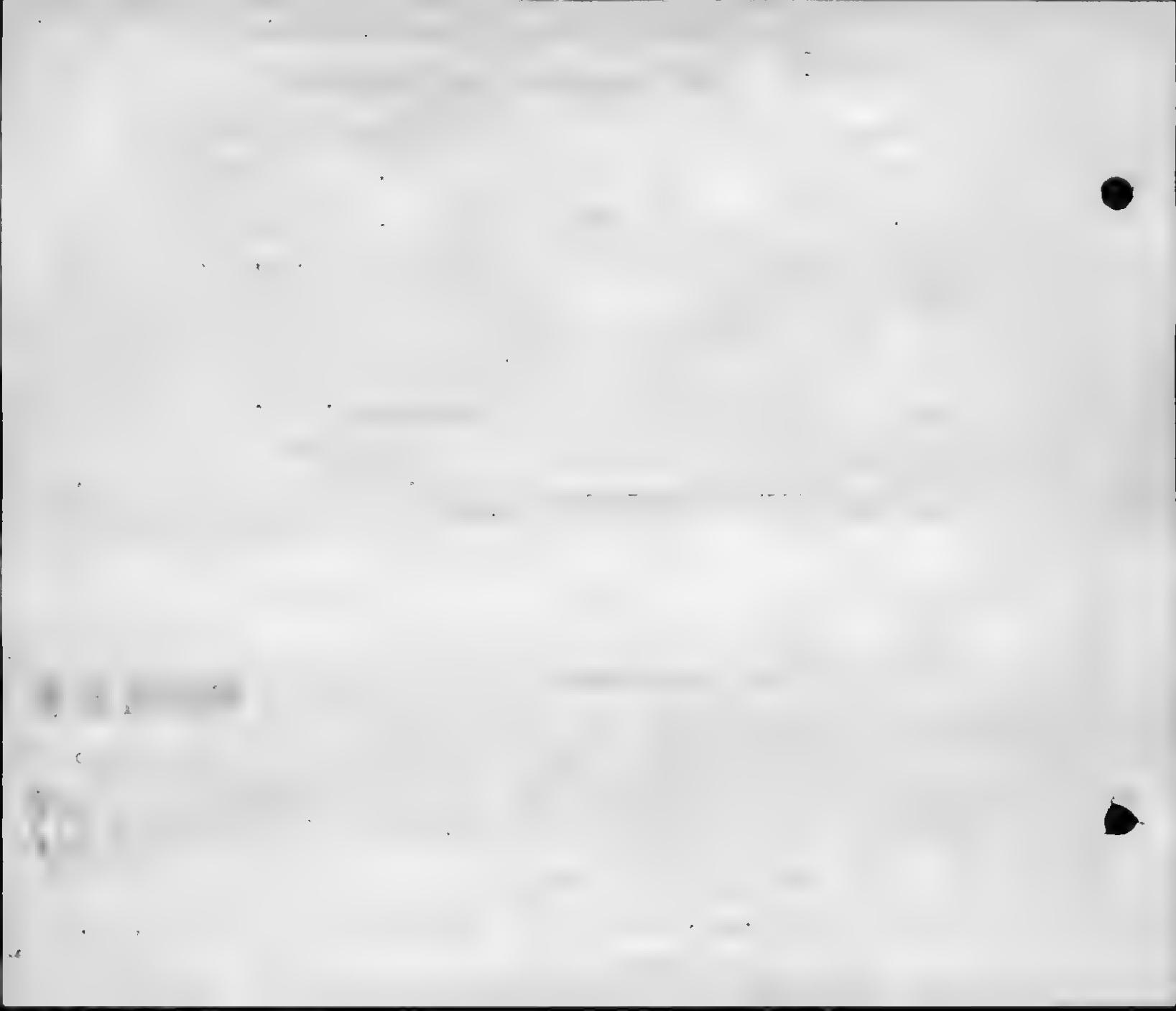
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01640

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>					
COUNTY <i>Maryland</i>	MARYLAND	STATE <i>MD.</i>	COUNTY <i>HARFORD</i>				
CITY (If outside corporate limits, write RURAL OR give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN <i>MT. HORSE ROAD</i>	<i>Life</i>	TOWN <i>MT. HORSE ROAD</i>	X				
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS					
<b>3. NAME OF DECEASED</b> (Type or Print)		(First) <i>Augustus</i>	(Middle) <i>Foard</i>	(Last) <i>Durham</i>	<b>4. DATE OF DEATH</b> (Month) <i>Feb.</i> 19, 1955	(Day)	(Year)
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Mar 1, 1888</i>	9. AGE last birthday <i>66 yrs.</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>19</i>	12. IF UNDER 24 HRS. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM OWNER</i>	11. BIRTHPLACE (State or foreign country) <i>HARFORD CO. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>WILLIAM DURHAM</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA VIRGINIA FOARD</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-14-0247</i>		17. INFORMANT & ADDRESS <i>MRS. ANNA F. DURHAM, STREET, MI.</i>		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		1. <i>Coronary thrombosis, acute</i> 2. <i>Coronary thrombosis, previous attack.</i>			
IMMEDIATE CAUSE <i>Coronary thrombosis, acute</i>		DUE TO <i>Coronary thrombosis, previous attack.</i>		2. <i>years</i>			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO <i>Coronary thrombosis, previous attack.</i>					
(A) <i>Coronary thrombosis, acute</i>		(B) <i>Coronary thrombosis, previous attack.</i>					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>Forest Hill, Maryland</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>
21d. TIME OF INJURY (Month) <i>Feb.</i> (Day) <i>19</i> (Year) <i>1955</i> (Hour) <i>2:30 P.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from alive on <i>Feb. 19, 1955</i> , to <i>Feb. 19, 1955</i> , that I last saw the deceased deceased before. alive on <i>Feb. 19, 1955</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Robert Barthel</i>		M.D.		ADDRESS (Street, city, town, state) <i>Forest Hill, Maryland</i>		DATE SIGNED <i>2-21-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>Feb. 22, 1955</i>		NAME OF CEMETERY OR CREMATORIAL <i>Jarrettsville</i>		LOCATION (City, town, or county) <i>Jarrettsville, Md.</i>	
24. REC'D BY REGISTRAR <i>Bevilla Foard</i>		REGISTRAR'S SIGNATURE <i>Bevilla Foard</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Barthel</i>		ADDRESS <i>Forest Hill, Maryland</i>	
DATE <i>2-21-55</i>							



## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1655

01641  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185

## 1. PLACE OF DEATH:

COUNTY

Harford Maryland MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

99 Haford Memorial D.O.A.

3. NAME OF  
DECEASED:  
(Type or Print)

(First) Esahel

(Middle)

(Last)

## 5. SEX:

M. 6. COLOR OR  
RACE:W. 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

8. DATE OF BIRTH:

Fulton

4/4/1889

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
or if retired)10b. KIND OF BUSINESS OR  
INDUSTRY:

Salesman VA Hosp. Chap. Pt.

11. BIRTHPLACE (State or foreign country):

Hintonville, Md.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME:

J.W. Fulton

14. MOTHER'S MAIDEN NAME:

Eloja Barrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

Yes WWI

16. SOCIAL SECURITY NO.: 214-18-7212

17. INFORMANT &amp; ADDRESS:

Mo. Mrs. Price, 613 Franklin, Hanover, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1 Immediate cause (a) Arteriosclerotic CV Disease

DUE TO (b) (c)

Antecedent cause(s) (d) (e) (f)

Diseases or conditions, if any, (g) (h) (i)

giving rise to the above cause DUE TO (j) (k) (l)

stating underlying cause last (m) (n) (o)

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes  No 21a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M. While at Not while  
at work  at work 

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

300

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01642

1672

## CERTIFICATE OF DEATH

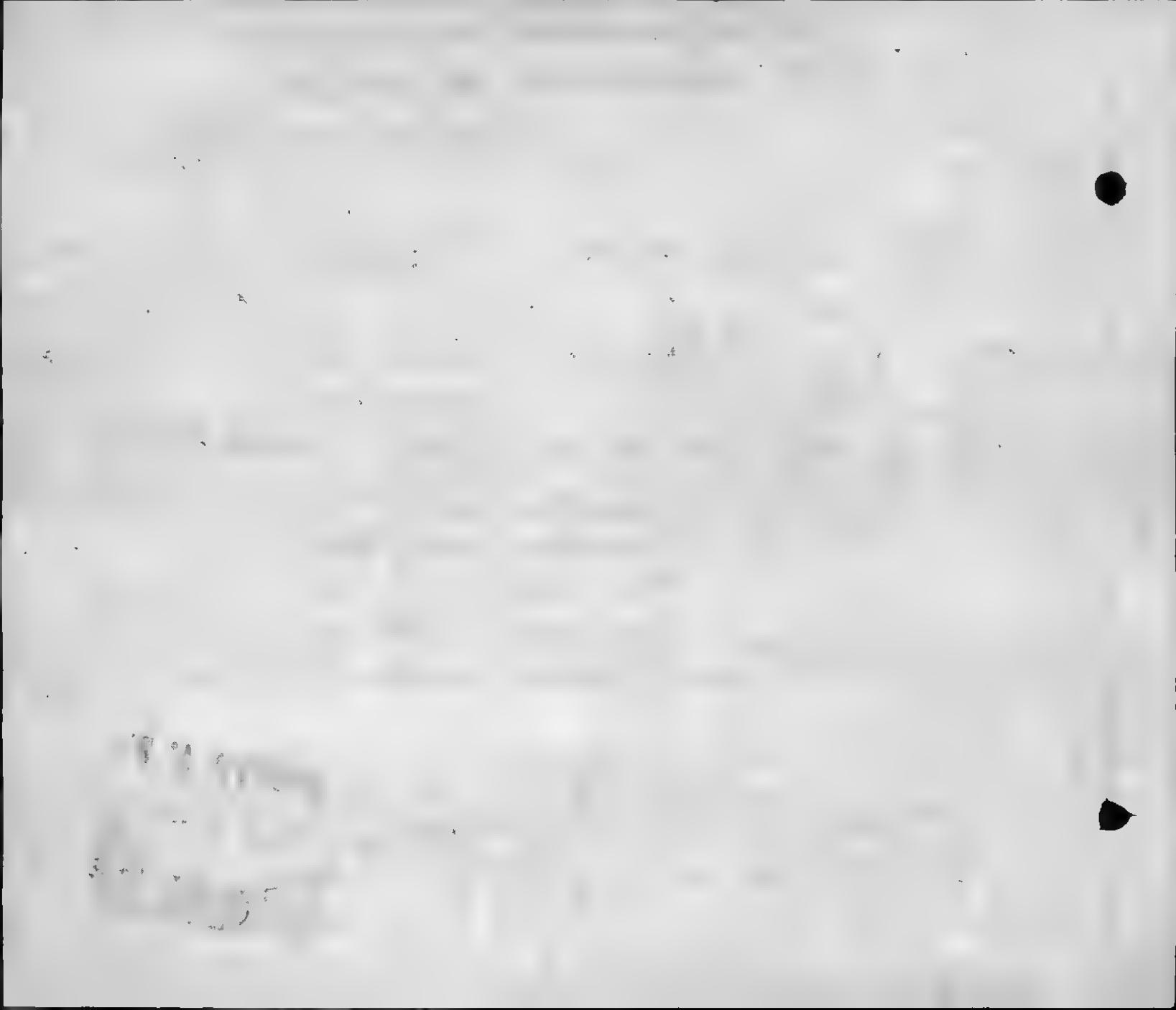
Reg. Dist. No. 182

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

**TO HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## INSTRUCTIONS

<b>1. PLACE OF DEATH</b> COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>ROCKS</b> TOWN <b>ROCKS</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rock Chrome Hill Rd.</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <b>MD</b> COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>ROCKS</b> TOWN <b>ROCKS</b> STREET ADDRESS <b>Rock Chrome Hill Rd.</b> (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) <b>JACKIE</b> (Middle) <b>RAY</b> (Last) <b>GREENE</b> (Type or Print)				<b>4. DATE (Month) (Day) (Year)</b> <b>FEB 14 1955</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>FEB 14, 1955</b>	9. AGE last birthday <b>NEWBORN</b>	IF UNDER 1 YEAR (IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> )		
<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>—</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>			
<b>13. FATHER'S NAME</b> <b>Raymond Columbus Greene</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nadean Rosella Blackburn</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>—</b>			
<b>17. INFORMANT &amp; ADDRESS</b> <b>Father</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <b>762.5 IMMEDIATE CAUSE</b> (A) <b>Aspirated amniotic fluid</b> ANTECEDENT CAUSE(S) DUE TO <b>Prematurity - aborted at</b> DISEASES OR CONDITIONS, IF ANY, (B) <b>22 weeks pregnancy.</b> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>None</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>—</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>—</b>		<b>18. MEDICAL CERTIFICATION</b> <b>INTERVAL BETWEEN ONSET AND DEATH,</b> <b>2 min</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <input type="checkbox"/> (If either, notify medical examiner)		<b>21b. PLACE (Home, farm, factory, street, office bldg., etc.)</b> <b>—</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> <b>—</b> (County) <b>—</b> (State) <b>—</b>			
<b>21d. TIME OF INJURY</b> (Month) <b>—</b> (Day) <b>—</b> (Year) <b>—</b> (Hour) <b>—</b>		<b>21e. INJURY OCCURRED</b> M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>—</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>14 Feb., 1955</b> , <b>to</b> <b>14 Feb., 1955</b> , <b>that I last saw the deceased</b> <b>alive on</b> <b>14 Feb., 1955</b> , <b>and that death occurred at</b> <b>10132 1/2</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <b>Philip W. Deuman</b> <b>M.D.</b> <b>307 Hickory, Bel Air, Md. 14 Feb 1955</b> <b>ADDRESS</b> <b>(Street, city, town, state)</b> <b>DATE SIGNED</b> <b>14 Feb 1955</b> <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b> <b>Feb. 16, 1955</b> <b>Location (City, town, or county)</b> <b>Baltimore County, Maryland</b> <b>(State)</b> <b>DATE THEREOF</b> <b>NAME OF CEMETERY OR OTHER PLACE</b> <b>Major Cr. &amp; Harford Co., Md.</b> <b>REGISTRAR'S SIGNATURE</b> <b>Brucilla Fordwood</b> <b>ADDRESS</b> <b>H.S. Bailey, Arlington, Md.</b>							
<b>24. REC'D BY REGISTRAR</b> <b>VS AISC 1-55 10A</b> <b>DATE</b> <b>2-15-65</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>—</b> <b>ADDRESS</b> <b>—</b>					





RECEIVED  
BUREAU V. S.

FEB

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1673

## CERTIFICATE OF DEATH

Reg. Dist. No.

01644

785

## 1. PLACE OF DEATH:

COUNTY Harford MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town  
 TOWN Havre de Grace, Rural 18 Mos.

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS 000 Havre de Grace Heights

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Harford  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Havre de Grace, Rural

STREET ADDRESS (If rural give location)  
 Havre de Grace Heights

3. NAME OF  
 DECEASED: (First) Lucy (Middle) Ann (Last) Grover

4. DATE (Month) (Day) (Year)  
 OF DEATH: Feb. 23 1955

5. SEX: 6. COLOR OR  
 RACE: Female White 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Married)

8. DATE OF BIRTH:  
 1-16-1884

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
 yrs. Months Days Hours Min.

71

10a. USUAL OCCUPATION Give kind of  
 work done during most of working life,  
 even if retired Domestic

10b. KIND OF BUSINESS OR  
 INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT  
 COUNTRY?  
 Penna. USA

## 13. FATHER'S NAME:

Henry B. Jones

## 14. MOTHER'S MAIDEN NAME:

Delilah Carlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
 No

16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: Havre de Grace, Md.  
 220-34-5107 Mrs Carl Wheeler, Havre de Grace, Height

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

45.2/1  
 Immediate cause

(a) DUE TO

Coronary Occlusion

Interval Between  
 Onset And Death

Sudden

## Antecedent causes (s)

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last.

(b) DUE TO

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
 related to the disease or condition causing death.

none

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes  No

1  
 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,  
 SUICIDE OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
 HOMICIDE INJURY

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?  
 OF While at Not While  
 INJURY m. Work  At Work

22. I hereby certify that I attended the deceased from 2/23 1955, to 2/23 1955, that I last saw the deceased

alive on 2/23 1955, and that death occurred at home from the causes and on the date stated above.  
 SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph R. Dale

Physician

430 pm

2/24/55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
 REMOVAL (Specify) 2-26-1955 Hopewell Port Deposit, Md. Rural

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
 REGISTRAR Feb. 24-1955 A. L. Lewis on 4th Street, Patterson & Son Perryville, Md.

J.V.S.

1955



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01645

1657

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford MARYLAND Hare - dehse 15 min.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md COUNTY Harford Aberdeen 31 (If sure give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	71 Harford Memorial Hospital	STREET ADDRESS	422 Louraine St
<b>3. NAME OF</b> (First) (Middle) (Last) (Type or Print)		<b>4. DATE</b> (Month) (Day) (Year) OF DEATH 2-19 1955	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH July 13-1889
9. AGE last birthday 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME (Unknown) Partyka		
14. MOTHER'S MAIDEN NAME (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS George J. Gula son	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
23. IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GENERALIZED ARTERIOSCLEROSIS GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) 2 WEEKS 10 YEARS			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work	21f. WHERE DID INJURY OCCUR? (City or town) Aberdeen, Md.	(County) (State)
21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPTEMBER 1952 to FEBRUARY 1955, that I last saw the deceased alive on FEB. 19, 1955, and that death occurred at 6 <sup>00</sup> P.M. from the causes and on the date stated above. SIGNATURE Brown McDonald, M.D. ADDRESS (Street, city, town, state) Aberdeen, Md. DATE SIGNED FEB 19, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	DATE THEREOF Feb 20-1955	NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	LOCATION (City, town, or county) Islip, Long Island N.Y.
24. REC'D BY REGISTRAR DATE Feb. 21-1955	REGISTRAR'S SIGNATURE A. F. Lewis M.A.	25. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring	ADDRESS Aberdeen, Md.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1658

## CERTIFICATE OF DEATH

01646

Reg. Dist. No. 185-

**ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## INSTRUCTIONS

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY OR TOWN	COUNTY PENNSYLVANIA PHILADELPHIA (If rural give location)
24 HARFORD 24 Havre de Grace	MARYLAND (Last)	PHILADELPHIA 314 N. 41 <sup>ST</sup> STREET	75X-7
HOSPITAL OR INSTITUTION OR STREET ADDRESS	314 N. 41 <sup>ST</sup> STREET		
71 Harford Mem. Hospital	314 N. 41 <sup>ST</sup> STREET		
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE</b> (Month) (Day) (Year)	
EDWARD ELIAH HARRIS		2 22 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male Negro		Widowed	1-15-1884
9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
71 yrs.	Months	Days	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
LABORER		LONGSHOREMAN	ATLANTA, GA.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
NO RECORD		NO RECORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
—		NONE	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
MRS SUSIE LEE-HAURE-DE GRACE		Congestive Heart Failure	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST, DUE TO			
260.0 (C) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/21/55, 1955, to 2/22, 1955, that I last saw the deceased alive on 2/22, 1955, and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
George J. Stansbury		DATE SIGNED 2/23/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORIUM	
BURIAL		LOCATION (City, town, or county) SWANS CREEK - MD	
DATE THEREOF		(State)	
2-27-55 UNION METHODIST CEM.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE	
Feb. 24, 1955		ADDRESS	
G. L. Lewis m/s		Elmer E. Bullock - HAURE-DE GRACE	

18<sup>th</sup> Jan

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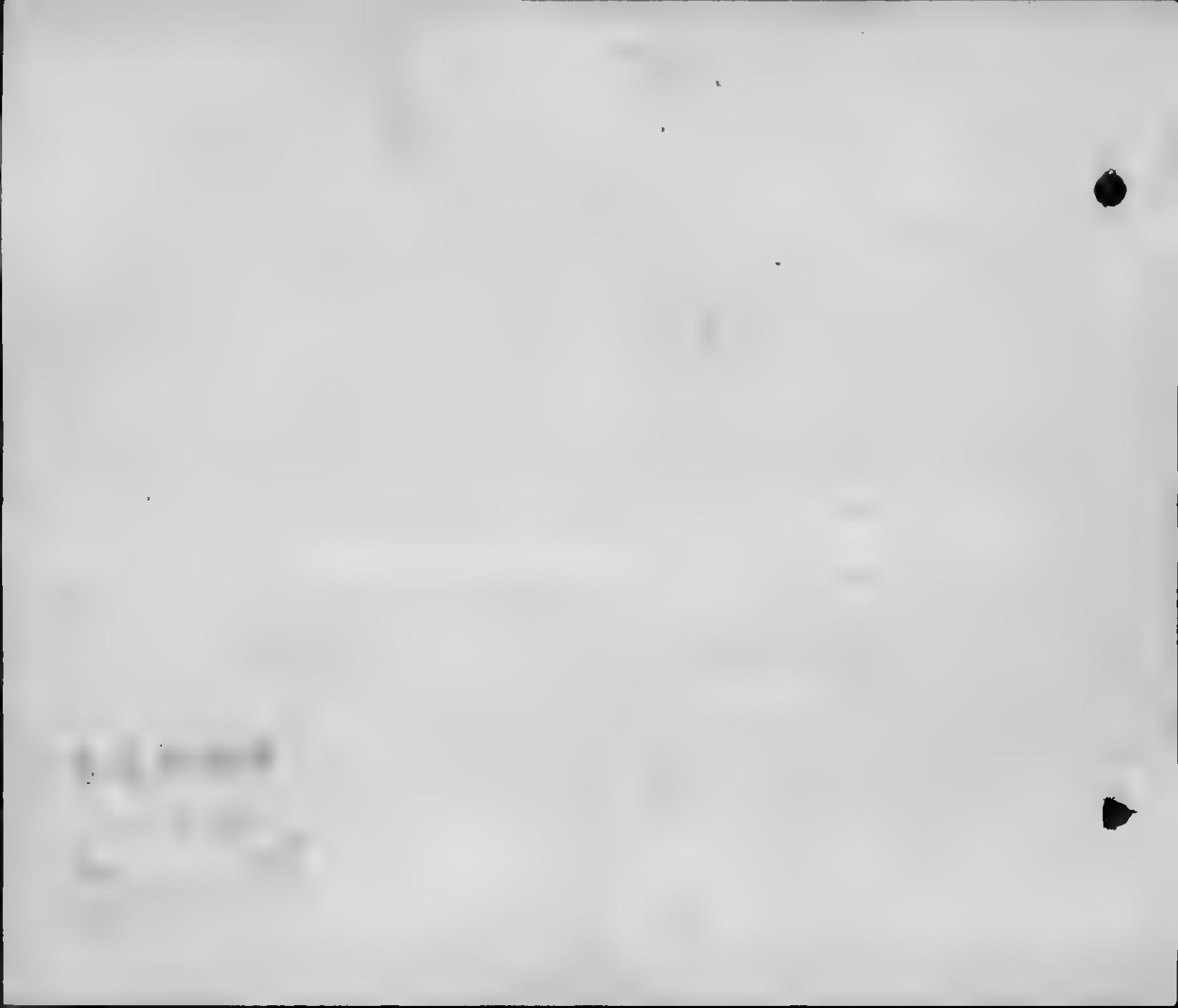
01647  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 183-

1. PLACE OF DEATH:  COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED:  STATE <u>Md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Sainte Marie</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Perryman</u>	
LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 20 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 27 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work even if retired) <u>Retired Crop Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country): <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Evan Hughes</u>		14. MOTHER'S MAIDEN NAME: <u>Darrah Gorrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.: <u>213-28-0284</u>	
(If Yes, give war or dates of service) <u>Mr</u>		17. INFORMANT & ADDRESS: <u>Mrs. Matul Russell</u> <u>Aberdeen, Md., U.S.A.</u>	
18. MEDICAL CERTIFICATION INTERNAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  816X Immediate cause (a) <u>Fracture skull</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) .... giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture R femur</u> <u>Fracture ribs, multiple</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, of street, office bldg, etc.) INJURY <u>House</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2/20/55 8:55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
M.		21f. HOW DID INJURY OCCUR? <u>Auto accident, auto - auto type</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Gerald C Palmer</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 23 1955</u> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <u>Rock Hill Cemetery Harford Co. Md.</u>	
DATE RECD BY LOCAL REG. <u>Feb. 23 1955</u>		REG. NUMBER <u>1. L. Lewis m d.</u> 24. FUNERAL DIRECTOR ADDRESS <u>F. S. Bailey</u> <u>Harpington Md.</u>	
REG. NUMBER		REG. NUMBER	

MARGIN RECEIVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC -55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

1660

01648

**CERTIFICATE OF DEATH**

Reg. Dist. No. 185-

1. PLACE OF DEATH CITY OR TOWN <i>Burford Maryland</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY OR TOWN STREET ADDRESS <i>Maryland County Burford House 24 137 Seaver</i>	
3. NAME OF DECEASED (Type or Print) <i>Oliver J. Jones</i>		4. DATE (Month) OF DEATH <i>2/26/55</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>Oct 31-1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Enginner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>	9. AGE last birthday IF UNDER 1 YEAR Months 73 yrs. IF UNDER 24 HRS. Days Hours Min. 19
13. FATHER'S NAME <i>John Jones</i>		14. MOTHER'S MAIDEN NAME <i>Margaret ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-09-5157</i>	
17. INFORMANT & ADDRESS <i>Frances E. Jones 137 Seaver</i>		18. MEDICAL CERTIFICATION <i>Cardiac Decompensation Coronary insufficiency Anterior clavicular Heart disease</i>	
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0 IMMEDIATE CAUSE Antecedent cause(s) due to Diseases or conditions, if any, giving rise to the above cause stating underlying cause last.</i>		19b. INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19c. DATE OF OPERATION		19d. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <i>Grace McFaul's house</i>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M. 2/26/55 1959</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/25/55</i> to <i>2/26/55</i> , that I last saw the deceased alive on <i>2/25/55</i> , 1955, and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above. SIGNATURE <i>John Wallman M.D.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/28/55</i>	
24. REC'D BY REGISTRAR DATE <i>Feb 28 1955 G.L. Lewis M.D.</i>		NAME OF CEMETERY OR CREMATORIUM <i>Angel Hill</i>	
REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) <i>Burford, Md.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			

18 2000

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** This law requires that the death certificate be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

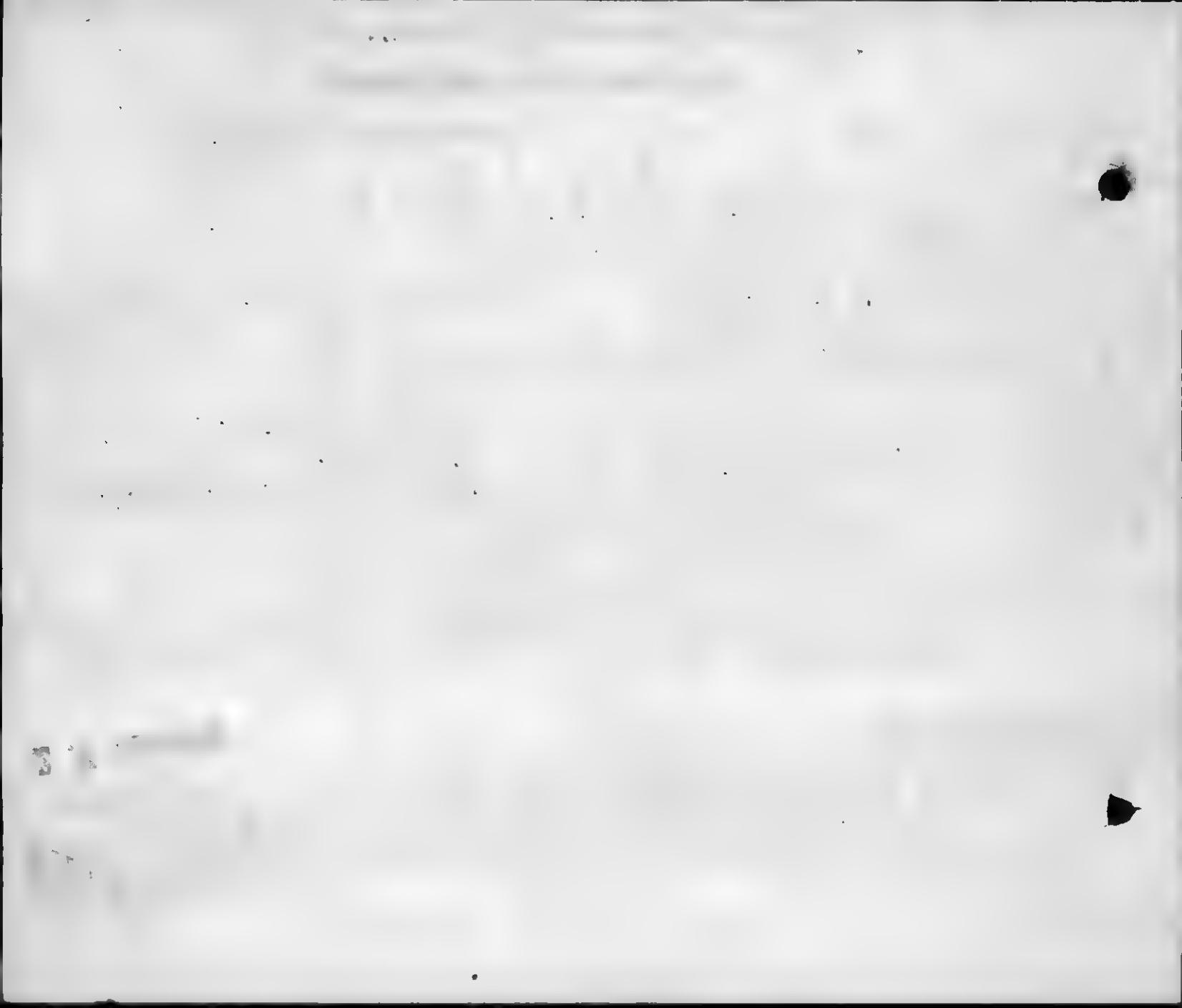
1661

01649

**CERTIFICATE OF DEATH**

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Baltimore</b>		STATE <b>MD</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Bell Air, Md.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>71 Harford Memorial Hospital</b>		LENGTH OF STAY (In this place) <b>36 hrs.</b> STREET ADDRESS <b>32</b>	
<b>3. NAME OF DECEASED</b> (First) <b>Baby Girl</b> (Middle) <b>Linger</b> (Last)		<b>4. DATE</b> (Month) <b>February</b> (Day) <b>18</b> (Year) <b>1955</b> <b>OF DEATH</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Neophyte</b>	<b>8. DATE OF BIRTH</b> <b>2-17-55</b> <b>36 hrs.</b> <b>9. AGE last birthday</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Harford Brace Hospital Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>	
<b>13. FATHER'S NAME</b> <b>Donald Linger</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine Valli</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>✓</b>	
<b>17. INFORMANT &amp; ADDRESS</b> <b>Donald Linger, 26 Shadwell St., Bellair</b>		<b>18. MEDICAL CERTIFICATION</b> <b>754.3 IMMEDIATE CAUSE</b> <b>(A) Intracranial Septal Defect (Congenital Birth</b> <b>ANTECEDENT CAUSE(S)</b> <b>DUE TO</b> <b>DISEASES OR CONDITIONS, IF ANY,</b> <b>(B)</b> <b>GIVING RISE TO THE ABOVE CAUSE</b> <b>STATING UNDERLYING CAUSE LAST.</b> <b>DUE TO</b> <b>(C)</b> <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING</b> <b>TO THE DEATH BUT NOT RELATED TO THE</b> <b>DISEASE OR CONDITION CAUSING DEATH.</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <input type="checkbox"/> (If either, notify medical examiner)		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.) <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) <b>Bell Air, Md.</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
<b>21d. TIME OF INJURY</b> (Month) <b>Feb.</b> (Day) <b>1955</b> (Year) <b>1955</b> (Hour) <b>12</b> <b>M.</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> <b>M.</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>2/17/55</b> <b>to</b> <b>2/18/55</b> , <b>that I last saw the deceased</b> <b>alive on</b> <b>2/18/55</b> , <b>and that death occurred at</b> <b>8:30 p.m.</b> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <b>I declare it</b> <b>Address</b> <b>172 Bell Air Blvd., Bellair, Md.</b> <b>DATE SIGNED</b> <b>2/19/55</b> <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b> <b>DATE THEREOF</b> <b>Feb. 19/55</b> <b>NAME OF CEMETERY OR CREMATORIUM</b> <b>Bell Air Memorial Gardens</b> <b>LOCATION (City, town, or county)</b> <b>Bell Air, Md.</b> <b>(State)</b> <b>24. REC'D BY REGISTRAR</b> <b>REGISTRAR'S SIGNATURE</b> <b>REG. DIST. NO.</b> <b>185</b> <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>J. L. Lewis M. D. Foster Funeral Home, Joseph W. Foster</b> <b>Bell Air, Md.</b>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1674 CERTIFICATE OF DEATH

01650

Reg. Dist. No. 182

1. PLACE OF DEATH.  COUNTY Harford MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural—Bel Air LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS 94 Almshouse—Harford Co.		2. USUAL RESIDENCE (HOME) OF DECEASED.  STATE Md COUNTY Harford CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Joppa, Maryland (If rural give location)	
3. NAME OF DECEASED. (First) ELBERT (Middle) A (Last) LOWER Y		4. DATE (Month) (Day) (Year) OF DEATH: February 14 1955	
5. SEX: Male 6. COLOR OR RACE Negro 7. SINGLE, MARRIED WIDOWED, DIVORCED. (Specify): Wid.		8. DATE OF BIRTH: 20th March 1888 9. AGE last birthday 66 IF UNDER 1 YEAR, MONTHS, DAYS, HOURS, MIN.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B KIND OF BUSINESS OR INDUSTRY: Farm 11. BIRTHPLACE (State or foreign country): Md.	
13. FATHER'S NAME: Lewis Lowery		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. MEDICAL CERTIFICATION  I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE 443X (A) CEREBRAL THROMBOSIS DUE TO ANTECEDENT CAUSE (B) HYPER TENSIVE CARDIC-VASCULAR DISEASE DUE TO STATING UNDERLYING CAUSE LAST.  (C)	
		INTERVAL BETWEEN ONSET AND DEATH 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 20, 1955 to Feb. 14, 1955, that I last saw the deceased alive on Feb. 12, 1955, and that death occurred at 8:30 A.M. from the causes and on the date stated above. SIGNATURE Willard P. Hudson M.D. Forest Hill, M.d. DATE SIGNED 2-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/17/55 NAME OF CEMETERY OR CREMATORIAL Mt. Zion Methodist LOCATION (City, town, or county) Mountains, Maryland (State)	
DATE REC'D BY LOCAL REGISTRAR 2/16/55		REGISTRAR'S SIGNATURE Rosella Fowurd 24. FUNERAL DIRECTOR ADDRESS Atelia G. Bullock-Harold Grace, M.d.	

BULAWY'S

FEE

WILCEAU VILLAGE

01651

MARYLAND 1675

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
<i>Hanford</i>		MARYLAND <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Bell-Air Rural</i>		OR TOWN <i>Bell - Air Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Walter Nursing Home</i>		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Ruth Ann McDoon</i>		(Month) (Day) (Year) <i>February 22 1955</i>	
5. SEX <i>Female White</i>		6. MARRIED WIDOWED, DIVORCED (Specify)	
		7. DATE OF BIRTH <i>Nov. 11, 1872</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework At Home</i>		9. AGE last birthday If under 1 year Months Days Hours Min. <i>82 yrs.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>		11. BIRTHPLACE (State or foreign country) <i>Hanford Co., Md.</i>	
13. FATHER'S NAME <i>John Darn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yrs. or month) (If yes, give date of service) <i>1910</i>		16. SOCIAL SECURITY NO. <i>Mc 74</i>	
17. INFORMANT AND ADDRESS <i>John Darn</i>		18. MEDICAL CERTIFICATION <i>Port H. &amp; Port, Anterior sclerotic C V disease</i>	
19. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. TIME (Month) (Day) (Year) (Hour) OF INJURY	
PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
23. BURIAL, Cremation REMAINS, ETC. DATE REG. NO.		NAME OF CEMETERY OR CREMATORIUM <i>Belair M. Cem.</i>	
DATE BURN'D BY LOCAL REG. NO.		LOCATION (City, town, or county) <i>Hanford Co., Md.</i>	
24. FUNERAL DIRECTOR REG. NO.		ADDRESS <i>H. S. Bailey</i>	
		ADDRESS <i>Darlington, Md.</i>	

NUMBER 4

MAR 7

LIBRARY  
UNIVERSITY OF TORONTO LIBRARIES  
SERIALS SECTION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01652

1676

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY Harford MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) Bel Air, Maryland (in this place)  
 TOWN 6 days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Harford Convalescent Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Harford  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Kalmar (if rural give location)  
 STREET ADDRESS Bel-Air P. D.

## 3. NAME OF DECEASED: (First)

G. SHERMAN

## (Middle)

## (Last)

MINK

## 4. DATE (Month)

## (Day)

## (Year)

Feb 21955

## 5. SEX:

m.

## 6. COLOR OR RACE:

w7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):widower

## 8. DATE OF BIRTH:

186491

yrs.

Months

Days

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

farmer

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Ash Co. N.C.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME:

not known

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Oscar H. Mink, Rocke, Md.

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

## (A) DUE TO

CORONARY OCCLUSION

## INTERVAL BETWEEN ONSET AND DEATH

1 hr.

## ANTECEDENT CAUSE (S)

## (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

Chn. CARDIO-VASCULAR DISEASE

## (C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Chn. ARTHRITIS

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

## 21E. INJURY OCCURRED While Not while at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3, 1948, to 2/2/53, 19 ..., that I last saw the deceased alive on 1/26/53, 19 .., and that death occurred at 10<sup>th</sup> P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

Feb 5, 1955Bel Air Memorial Gardens Bel Air, Harford Co. - Md.

DATE REC'D BY LOCAL REGISTRAR

2-4-55

REGISTRAR'S SIGNATURE

Francesca Fourwood

## 24. FUNERAL DIRECTOR

ADDRESS

Martin G. Kurt, Jarrettsville, Md.

ПОЧАУ В.

**INSTRUCTIONS**

**ATTACH PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 145 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01653

1662

**CERTIFICATE OF DEATH**

Reg. Dist. No. ....

185-

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY HAVER DE GRACE, MD.
TOWN HAVER DE GRACE, MD.	LENGTH OF STAY (In this place) 12 HRS.	STREET ADDRESS 666 Green St	STREET ADDRESS HAVER DE GRACE, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital			
<b>3. NAME OF DECEASED (First) (Middle) (Last)</b> (Type or Print) George Nelson Mitchell		<b>4. DATE (Month) (Day) (Year)</b> February 18 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH JULY 21, 1889 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHAFFER		10b. KIND OF BUSINESS OR INDUSTRY PENITENTIARY	11. BIRTHPLACE (State or foreign country) HARFORD Co. MD
13. FATHER'S NAME Robert O Mitchell		14. MOTHER'S MAIDEN NAME MARY AMANDA WALKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) —		16. SOCIAL SECURITY NO. 217-05-7905	
17. INFORMANT & ADDRESS G. NELSON MITCHELL, HAVER DE GRACE		18. MEDICAL CERTIFICATION ACUTE CORONARY OCCLUSION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  420.1 IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR? Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from..... 19..... to..... 19....., that I last saw the deceased alive on..... 19....., and that death occurred at..... 9:30 AM, from the causes and on the date stated above. SIGNATURE B. J. Remmey M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 130 PAL		DATE THEREOF FEB 21 1955	
NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEM.		LOCATION (City, town, or county) HAVER DE GRACE, MD.	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE A. L. Lewis M.D. & P. Madison Whitehall HAVER DE GRACE	
DATE FEB 21 1955 - A. L. Lewis M.D. & P. Madison Whitehall HAVER DE GRACE		ADDRESS	

SUNG V. G.

125



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01654

Reg. Dist. No. 182

## CERTIFICATE OF DEATH

1677

1. PLACE OF DEATH: COUNTY <b>HARFORD</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Oylesville Md.</b>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>HARFORD</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Oylesville Md.</b> STREET ADDRESS <b>Oylesville Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS:							
3. NAME OF DECEASED: (Type or Print)		(First) <b>Edward</b> (Middle) <b>O.</b> (Last) <b>Mitzel</b>		(Date)		4. DATE OF DEATH: <b>Feb. 15 - 1955</b>	
5. SEX: <b>Male</b>		6. COLOR OF RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>		8. DATE OF BIRTH: <b>Oct. 12-1897</b>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Farm</b>		11. BIRTHPLACE (State or foreign country): <b>Albert Mitzel Oylesville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.S.A.</b>	
13. FATHER'S NAME: <b>Joseph Mitzel</b>				14. MOTHER'S MAIDEN NAME: <b>Emma Daniels</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.: <b>123-45-6789</b>		17. INFORMANT & ADDRESS: <b>Albert Mitzel Oylesville Md.</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1</b> Immediate cause		(a) DUE TO <b>Coronary Thrombosis.</b>				Interval Between Onset And Death <b>10 days.</b>	
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) DUE TO <b>Arteriosclerosis. Chronic Myocarditis?</b>					
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)		(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?				
m.							
22. I hereby certify that I attended the deceased from <b>Dec 10, 1954</b> , to <b>Dec 14, 1955</b> , that I last saw the deceased alive on <b>Dec 14, 1955</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above. SIGNATURE <b>Edward H. Nyson</b> ADDRESS <b>Hawn Grove Pa.</b> DATE SIGNED <b>Feb 17, 1955</b>							
23. BURIAL, CREMATION REMOVAL SPECIFY		DATE THEREOF <b>Feb 19-1955</b>		NAME OF CEMETERY OR CREMATORIUM <b>Windsor Cemetery</b>		LOCATION (City, town, or county) <b>Windsor Cemetery Co.</b> (State) <b>Pa.</b>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Priscilla Lowwood</b>		GENERAL DIRECTOR <b>Edith W. Graham Stewart</b>		ADDRESS <b>Stewartown Pa.</b>	

MARGIN RESERVE FOR BINDING

**WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V5-A15

BUREAU V. S.

EB

JPG

100

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

1678

01656

**CERTIFICATE OF DEATH**

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>X</i> Harford	MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <i>Abingdon</i>	STATE Maryland	COUNTY Harford CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Abingdon</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>DD</i>	LENGTH OF STAY (in this place) <i>lifetime</i>	STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Marie</b>		<b>4. DATE OF DEATH</b> <b>FEBRUARY 23 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. July, 21, 1900</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE last birthday <b>54</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME <b>Frederick Morlok</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Rosia De Martin</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Andrew G. Mouldsdale, Abingdon, Md.,</b>	
<b>18. MEDICAL CERTIFICATION</b> <i>4x</i> IMMEDIATE CAUSE (A) <b>GENERALIZED CARCINOMATOSIS</b> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) <b>ADENO CARCINOMA RECTO SIGMOID</b> " " GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <b>Jan. 29, 1955</b>		19b. MAJOR FINDINGS OF OPERATION <b>ADENO CARCINOMA RECTO SIGMOID WITH METASTASES</b>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>JULY 1954</b> to <b>23 Feb. 1955</b> , that I last saw the deceased alive on <b>22 Feb. 1955</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. SIGNATURE <i>Philip W. Neumann M.D.</i> ADDRESS (Street, city, town, state) <b>307 Hickory, Bel Air, Md.</b> DATE SIGNED <b>24 Feb. 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 26, 1955</b> NAME OF CEMETERY OR CREMATORIUM <b>St. Paul's Lutheran</b> LOCATION (City, town, or county) <b>Stepney, Harford, Md.</b>	
24. REC'D BY REGISTRAR <b>Feb. 26, 1955</b>		REGISTRAR'S SIGNATURE <b>Norma G. Moore</b> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Howard K. McCombs &amp; Son, Abingdon, Md.</b>	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

01655

1663

**CERTIFICATE OF DEATH**

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
CITY <small>(If outside corporate limits, write RURAL OR and give nearest town)</small> TOWN <b>HARFORD</b>		STATE <b>Maryland</b> COUNTY <b>HARFORD</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>HARFORD MEMORIAL Hosp.</b>		CITY <small>(If outside corporate limits, write RURAL and give nearest town)</small> TOWN <b>Whiteford</b>	
LENGTH OF STAY (in this place) <b>13 HRS.</b>		STREET ADDRESS <small>(If rural give location)</small>	
<b>3. NAME OF DECEASED</b> (First) <b>HENRY</b> (Middle) <b>JAMES</b> (Last) <b>Norris</b> (Type or Print)		<b>4. DATE</b> (Month) <b>February</b> (Day) <b>13</b> (Year) <b>1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2, 8, 1868</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if part-time) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MATTHEW NORRIS</b>		14. MOTHER'S MAIDEN NAME <b>SUSANNA GIFFING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <b>X Blayette</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) <b>Coronary occlusion with myocardial infarction</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic cardiovascular disease</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Bronchopneumonia (2) Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <small>IF EITHER, NOTIFY MEDICAL EXAMINER</small>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) <b>Feb.</b> (Day) <b>12th</b> (Year) <b>1955</b>		21e. INJURY OCCURRED M. <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 12th, 1955</b> , to <b>Feb. 13th, 1955</b> , that I last saw the deceased alive on <b>Feb. 12th, 1955</b> and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. <b>SIGNATURE</b> <i>Edward J. Lee</i> <b>M.D.</b> <i>420 N Union Ave, Havre de Grace, Md. 21335</i> <b>DATE SIGNED</b> <i>2/13/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>FEB. 16, 1955</b> NAME OF CEMETERY OR CREMATORIUM <b>SLATE RIDGE</b> LOCATION (City, town, or county) <b>DELA. PA.</b> (State) <i>Delta, Pa.</i>	
24. REC'D BY REGISTRAR <b>Lewis M. John</b>		REGISTRAR'S SIGNATURE <b>L. Lewis M. John</b> 25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Hartman - Delta Pa.</b> ADDRESS	
DATE <b>Feb. 14-55</b>			

MURAU V. S

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REGULATED

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01657

Reg. Dist.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

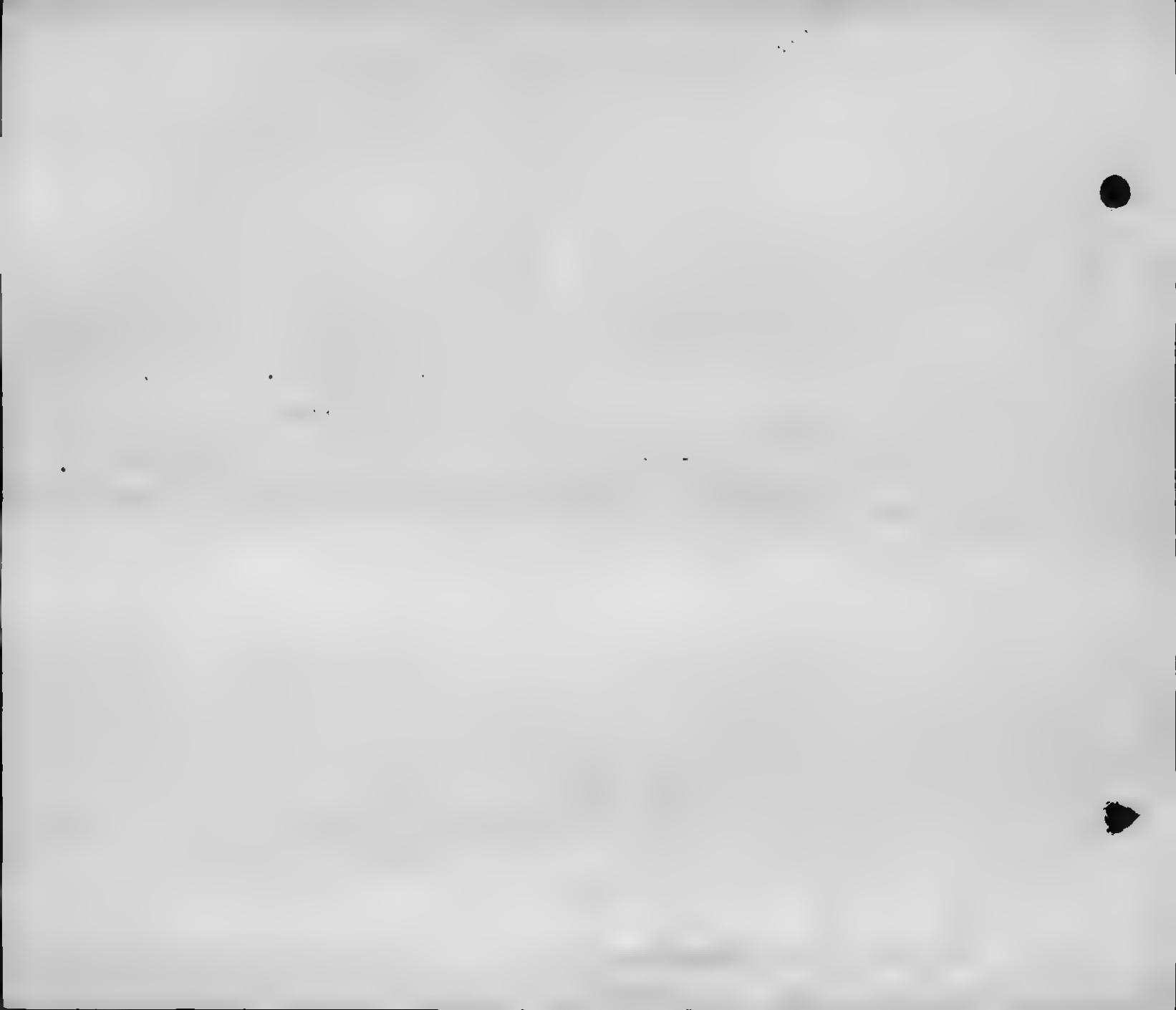
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bel Air		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bel Air	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 308 N. Main Street		STREET ADDRESS (If rural, give location) 308 N. Main Street	
3. NAME OF DECEASED: (Type or Print) MORMAN MURRAY PRATHER		4. DATE OF DEATH Feb. 16 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, DIVORCED, BEWIDOWED: (Specify): X X X X	8. DATE OF BIRTH: 9/30/1905
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): W. M. Dairy		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME: William Francis Prather		14. MOTHER'S MAIDEN NAME: Isabella Clendenin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY No.: 212-03-2977	
17. INFORMANT & ADDRESS: Mrs. Ruth Russe' Prather Belair, Md.		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause (a) ... Calcific aortic stenosis. DUE TO  Antecedent cause(s) (b) ... Myocardial hypertrophy Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at M. work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE WHEREOF Feb 19 1955	
DATE REC'D BY LOCAL REG. 3/1/55		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, Town, or county) Julian Md	
REGISTRAR'S SIGNATURE A. W. Hedrick		DATE SIGNED Feb. 16, 1955	
24. FUNERAL DIRECTOR		ADDRESS	



## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1679

## CERTIFICATE OF DEATH

01658

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Aberdeen		31 days		TOWN Aberdeen			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Md.				STREET ADDRESS (If rural give location) 302 Old Post Road			
3. NAME OF DECEASED (First) Verna DOTT SHAFFER (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH Feb. 19 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Jan. 20, 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Shaffer				14. MOTHER'S MAIDEN NAME Georgenia D. Erickson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO - - - - -		17. INFORMANT & ADDRESS Robert J Shaffer 302 Old Post Rd, Aberdeen, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Cerebral Anoxia with resultant inability to swallow 31 days ANTECEDENT CAUSE(S) DUE TO (B) Atelectasis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 19 1955, to Feb 19 1955, that I last saw the deceased alive on Feb 19 1955, and that death occurred at 1:10 PM, from the causes and on the date stated above ADDRESS (Street, city, town, state) 19Feb55 SIGNATURE Robert D. Hume Jr. M.A. MC ROBERT D HUME JR. M.A. MC DATE THEREOF 2/22/55 NAME OF CEMETERY OR CREMATORIAL M.D. U.S. Army Hosp., Aberdeen Proving Ground, Md. 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal LOCATION (City, town, or county) Jamestown New York DATE 2/22/55 REGISTRAR'S SIGNATURE Ellie G. Perry 24. REC'D BY REGISTRAR DATE 2/22/55 REGISTRAR'S SIGNATURE Ellie G. Perry 25. FUNERAL DIRECTOR'S SIGNATURE John G. Barrington Aberdeen Md. ADDRESS							

3A 195

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1680

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01659

## 1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSLENGTH OF STAY  
(in this place)

3 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Faleston

X

STREET  
ADDRESS

(If rural give location)

Rusale

X

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

## 5. SEX

M

6. COLOR OR  
RACE:

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify)

Single

## 8. DATE OF BIRTH:

Oct 17, 1950

4. DATE (Month)  
OF  
DEATH

Feb 6

1955

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life.  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

York Pa

12. CITIZEN OF WHAT  
COUNTRY?

US

## 13. FATHER'S NAME:

Jesse Sparks

## 14. MOTHER'S MAIDEN NAME:

Mary Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No

## 16. SOCIAL SECURITY NO.

— — —

## 17. INFORMANT &amp; ADDRESS:

Jesse Sparks, Faleston md

INTERVAL BETWEEN  
ONSET AND DEATH

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

051X

## IMMEDIATE CAUSE

(A) Septicemia

## ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B) Due to

ac. streptococcal Tonsillitis

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

M.

## 22. I hereby certify that I attended the deceased from Feb 5, 1955, to Feb 5, 1955, that I last saw the deceased

alive on Feb 5, 1955, and that death occurred at 12:15 AM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Wellard P. Henderson

M.D. Forest Hill

2/7/55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

Burial

Feb 8, 1955

Friendship Methodist

Faleston

md

Cremation

Burial

Cremation

Burial

Cremation

S A 2000

500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
age is especially important. Physical: please write the causes of death clearly and legibly.

1665

01660

Reg. Dist.

No. 1855

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

COUNTY

HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

HAURE de GRACE

LENGTH OF STAY  
(In this place)

4 YRS.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)

RONALD

(Middle)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

HARFORD

CITY (If outside corporate limits write RURAL and give nearest town)  
OR

TOWN

HAURE de GRACE

STREET  
ADDRESS

(If rural, give location)

131 WEBER STREET

24

4. DATE  
OF  
DEATH

2 - 19 - 18 1955

5. SEX:

MALE

6. COLOR OR  
RACE:

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

SINGLE

8. DATE OF BIRTH:

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):

NONE

10b. KIND OF BUSINESS OR  
INDUSTRY:

NONE

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs.

4

Months

Days

Hours

Min.

## 11. BIRTHPLACE (State or foreign country):

HAURE de GRACE

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME:

EUGENE I STILLMAN

14. MOTHER'S MAIDEN NAME:

RUBY G SAYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Y

10

16. SOCIAL SECURITY NO.:

NONE

17. INFORMANT &amp; ADDRESS:

EUGENE I STILLMAN, 131 WEBER ST, HAURE de GRACE, MD

18. MEDICAL CERTIFICATION

576X

Immediate cause

(a)

DUE TO

Generalized peritonitis

1000 V. S.

HEC

17

1681

01662  
Reg. Dist.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 180

## I. PLACE OF DEATH:

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town) AbingdonLENGTH OF STAY  
(in this place)  
4 yrs.,HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print) James(First) (Middle) (Last)  
F. Van Valkenburgh, Jr.,4. DATE  
(Month) (Day) (Year)  
OF  
DEATH February 18 19555. SEX: male 6. COLOR OR  
RACE: white7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): married8. DATE OF BIRTH:  
Feb. 8, 19209. AGE last birthday:  
35 yrs.IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired): Engineer10b. KIND OF BUSINESS OR  
INDUSTRY: Aircraft11. BIRTHPLACE (State or foreign country):  
North Carolina12. CITIZEN OF WHAT  
COUNTRY: U.S.A.

## 13. FATHER'S NAME:

James F. Van Valkenburgh

## 14. MOTHER'S MAIDEN NAME:

Annie Boling

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service) yes ✓ W.W. II

16. SOCIAL SECURITY NO.: 240-16-5753

## 17. INFORMANT &amp; ADDRESS:

Regina M. Van Valkenburgh, Abingdon, Md.,

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:420.1  
Immediate cause (a) ....  
DUE TO

Coronary occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

## Antecedent cause(s)

Diseases or conditions, if any, (b) ....  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  OF  
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
of street, office bldg., etc.,  
INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M.21e. INJURY OCCURRED  
While at Not while  
work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAMDATE SIGNED  
2-18-195523. BURIAL, CREMATION,  
REMOVAL (Specify): Removal

DATE THEREOF Feb. 18, 1955

NAME OF CEMETERY OR CREMATORIAL Groce Funeral Home

LOCATION (City, town, or county) Asheville (State) North Carolina

DATE REC'D BY LOCAL  
REG. Feb. 21, 1955

REGISTRAR'S SIGNATURE Norma B. Moore

24. FUNERAL DIRECTOR

ADDRESS Howard K. McComas &amp; Son, Abingdon, Md.

PAGE ONE  
FEB

1960

1666

01663  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 183-

## 1. PLACE OF DEATH:

Harford

Maryland  
MARYLANDCITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)  
16 hrs.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Harford Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED  
Maryland  
STATE  
COUNTYCITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS  
(If rural, give location)

425 N. Union

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

February 1 1955

## 5. SEX:

Male

6. COLOR OR  
RACE:

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,

Widowed, Divorced

## 8. DATE OF BIRTH:

7/12/1884

## 9. AGE last birthday:

70  
yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):

Metallurgist

10b. KIND OF BUSINESS OR  
INDUSTRY:

Aberdeen Proving Ground

## 11. BIRTHPLACE (State or foreign country):

Lowell, Mass

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

James D. Weymouth

## 14. MOTHER'S MAIDEN NAME:

Elvira Limer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)(If Yes, give war or dates of  
service)

W.W.I

## 16. SOCIAL SECURITY NO.:

168-03-3531

## 17. INFORMANT &amp; ADDRESS:

Mrs. Alice G. M. Weymouth 1 Claude Grace Rd

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)  
DUE TO

communited fracture pelvis

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

## Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause  
stating underlying cause last (c)

DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

rupture urinary bladder

1 day

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
of street, office bldg, etc.,  
INJURY man/wife)

## 21c. (City or town) (County)

Harford Harford Md

(State)

21d. TIME (Month) (Year) (Hour)  
OF INJURY 12/31/55 6 P.M.21e. INJURY OCCURRED  
While at Not while  
work  at work 

## 21f. HOW DID INJURY OCCUR?

4nts accident, auto-pedestrian type

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

## SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.DATE SIGNED  
2/15/5523. BURIAL, CREMATION,  
REMOVAL (Specify):

Cremation

## DATE THEREOF

2/2/55

## NAME OF CEMETERY OR CREMATORIAL

Baltimore

## LOCATION (City, town, or county) (State)

Baltimore Md

## DATE REC'D BY LOCAL REG. OFFICER

Feb. 2-1955 A. D. Lewis M.D.

## REG. OFFICER'S SIGNATURE

A. D. Lewis M.D.

## 24. FUNERAL DIRECTOR

Burroughs &amp; Son

## ADDRESS

1 Claude Grace Rd

RECEIVED  
BUREAU V. S.

FEB 7 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1682

01664

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <input checked="" type="checkbox"/> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Harford Rural Bel Air Rural 90 Walters Nursing Home	MARYLAND LENGTH OF STAY (in this place) 8 MOS.	STATE Md. CITY OR TOWN Bel-Air Rural STREET ADDRESS (If rural give location)
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 15 1955	
5. SEX: Male COLOR OR RACE:	6. SINGLE, MARRIED MARRIED DIVORCED (Specify)	7. DATE OF BIRTH: Oct. 11, 1876	9. AGE last birthday 78 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper, Country Store		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore Co., Md., U. S. A.
13. FATHER'S NAME: Joseph B. Kinemiller		12. CITIZEN OF WHAT COUNTRY:	
14. MOTHER'S MAIDEN NAME: Anna Bowman		15. INFORMANT & ADDRESS: James G. Kinemiller Stewartstown, Pa.	
16. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE Diseases or conditions, if any, giving rise to the above cause stating underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
(A) DUE TO Cerebral Hemorrhage			
(B) DUE TO Chr. Cardio-vascular Disease		?	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 10, 1954, to Feb. 15, 1955, that I last saw the deceased alive on Feb. 14, 1955, and that death occurred at 3:00 P.M., from the causes and on the date stated above. SIGNATURE Willard P. Hudson			
ADDRESS M. D. Forest Hill, Md.		DATE SIGNED 2-15-55	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL SPECIMEN		NAME OF CEMETERY OR CREMATORIUM Burial Feb. 18, 1955 Stewartstown Cem. York Co., Penna.	
DATE REC'D BY LOCAL REGISTRAR 2/18/55		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE Priscilla Louwood		24. FUNERAL DIRECTOR ADDRESS H. D. Bailey, Parlington, Md.	

BUREAU V. S.

FEB 21 1955

RECEIVED